State of Wisconsin
Department of Health and Family Services

Jim Doyle, Governor
Helene Nelson, Secretary

May 14, 2004

Dear Friends of Public Health:

In follow-up to the Public Health Restructuring Report issued in February 2004, I commissioned a briefing paper on public health institutes to lay the foundation for a well-informed discussion of the options for Wisconsin.

This report, now published on the Department's web site at http://dhfs.wisconsin.gov/aboutDHFS/dph/restructure/index.htm identifies key issues for consideration. For each issue background information is provided, followed by Committee recommendations related to the issue area. The report also presents an analysis of the pros and cons of the alternative models identified by the Committee. The report does not make a recommendation on the scope or structure of a public health institute.

To develop this report, the Committee studied national research on Public Health Institutes; consulted with national experts at the National Network of Public Health Institutes; consulted with state government officials knowledgeable about the creation of state public authorities; consulted with state government staff with expertise in specialized areas; considered material provided by stakeholder groups; and reviewed background information on the state health plan, public health statutes, and current funding situation for public health.

We welcome your advice on this issue and encourage you to read the report, share it with your partners and provide comments. I believe that you will see in the report that we have addressed many issues and concerns that have been raised by stakeholders. We look forward to an open dialogue on these concepts, including at the upcoming joint conference of the Wisconsin Public Health Association and the Wisconsin Association of Local Health Departments and Boards on May 18 – 19, 2004 in Stevens Point.

Sincerely,

Helene Nelson
Secretary

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

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TO: Helene Nelson

FROM: Fredi Bove

DATE: May 14, 2004

RE: Public Health Institute Report

On behalf of the Committee you appointed, I am providing the Committee's report analyzing the possibility of establishing a Public Health Institute in Wisconsin. The Committee was charged with preparing a high level concept paper to lay out the issues and develop the pros and cons for a Wisconsin Public Health Institute.

This report identifies key issues for consideration. For each issue, background information is provided, followed by Committee recommendations related to the issue area. The report also presents an analysis of the pros and cons of the alternative models identified by the Committee.

The Committee completed its work within a two-month timeframe. To develop this report, the Committee studied national research on Public Health Institutes; consulted with national experts at the National Network of Public Health Institutes; consulted with state government officials knowledgeable about the creation of state public authorities; consulted with state government staff with expertise in specialized areas; considered material provided by stakeholder groups; and reviewed background information on the state health plan, public health statutes, and current funding situation for public health.

We understand that you will be seeking input from many people about the issues presented in this report. The report completed by the Committee is a high-level report, which we hope will facilitate a well-informed discussion of the options before the state.

We appreciate the opportunity to work on this project. The report was completed by the following Committee:

Chair – Fredi Bove, DHFS Office of Strategic Finance
Henry Anderson, DHFS Division of Public Health
Mary Jo Baisch, Public Health Advisory Committee
Terry Brandenberg, West Allis Health Department
Cindy Daggett, DHFS Budget Section
Millie Jones, DHFS Division of Public Health
Murray Katcher, DHFS Division of Public Health
Ron Laessig, Public Health Advisory Committee
Pat Remington, UW-Madison Medical School
Meg Taylor, DHFS Division of Public Health
Susan Wood – DHFS Division of Public Health

Report of the Committee to Develop Options for a Wisconsin Public Health Institute

May 14, 2004

Introduction

On February 26, 2004, DHFS Secretary Helene Nelson created a committee to examine the issues related to a Wisconsin Public Health Institute. The Committee was charged with: "preparing a concept paper to lay out the issues and develop the pros and cons for a Wisconsin Public Health Institute".

National Perspective on Institutes

Currently 18 states other than Wisconsin have established institutes to provide enhanced capacity in their public health systems. An additional 16 states are considering establishing an institute. California and Michigan have the largest and among the longest-standing institutes. Many of the other institutes are small and/or focussed on special topics. The institutes in other states provide some combination of policy research and development, program evaluation, professional and public education and training, advocacy, community capacity enhancement, community-needs assessments, facilitation of public health partnerships, data collection, outcome measurements and evaluations and technical assistance.

Some states have created an institute through authorizing legislation. In some states, the institutes may act as the agent of the state health department for some functions. The institutes are successful at securing grants from federal agencies, such as the Centers for Disease Control and Prevention (CDC) and the National Cancer Institute (NCI), and private foundations such as the Robert Wood Johnson Foundation. Of the 18 current public health institutes in other states, 13 are established as 501(c)(3) nonprofit organizations. The remaining institutes use a mix of organizational structures. All of the institutes in other states began on a small scale and grew gradually over time as project funding was secured from external sources. None of the institutes in other states at the outset assumed functions that were transferred from the state health department.

Wisconsin currently has 2 public health institutes: the Center for Urban Population and the Wisconsin Public Health and Health Policy Institute. The Center for Urban Population seeks to improve individual and population health through health services research, evaluations, professional education, and health promotion programming. The Wisconsin Public Health and Health Policy Institute serves as a focal point for applied public health and health policy within the University of Wisconsin-Madison Medical School as well as a bridge to public health and health policy practitioners in the state. Both are small, university-based institutes that carry out research on public health issues. These institutes are not the type of institute that is the subject of this paper.

Attachment 1 provides a matrix summarizing the key characteristics of the current public health institutes.

Establishing a Public Health Institute in Wisconsin

Over the past ten years the merits of creating a Public Health Institute in Wisconsin has been discussed by Department of Health and Family Services (DHFS) staff and members of the public health community. A Public Health Institute (PHI) can improve, strengthen, and help transform the Wisconsin public health system and thereby help achieve the goals in *Healthiest Wisconsin 2010*, the state health plan. A PHI could provide additional capacity and leadership for public health in the state, and serve as a bridge between the Department, academic institutions, and other public health partners. A PHI could expand the resources available to the public health system by tapping into new external funding sources. A PHI could promote economic development in Wisconsin by attracting public health and medical research investment and creating high-technology jobs in the medical research and health services research industries. A PHI could also help meet the objective of the Governor to reduce the size of state government—specifically the number of state government employees.

While a PHI offers many advantages, there is also some risk that embarking on a major structural change in the state's delivery system for public health could interfere with progress in achieving the goals set in the state health plan. The time and effort required to create an Institute need to come from the same human resources that support the current delivery system.

Wisconsin's Public Health System

Healthiest Wisconsin 2010, published by the Department of Health and Family Services (DHFS) in 2002, articulates the Wisconsin public health plan for the decade. The plan was the product of extensive collaboration among public health partners from all sectors throughout the state. The plan creates a common, shared vision and mission for the public health system in Wisconsin as the basis for a transformation of the public health system to eliminate health disparities and to promote and protect the health for all.

Healthiest Wisconsin 2010, the state plan, identifies 12 essential public health services which are shared by all partners in their endeavor to attain healthy people in healthy Wisconsin communities. These 12 essential public health services, which must be in place to sustain a strong public health system, are:

1. Monitor health status to identify community health problems.
2. Identify, investigate, control, and prevent health problems and environmental health hazards in the community.
3. Educate the public about current and emerging health issues.
4. Promote community partnerships to identify and solve health problems.

5. Create policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed health services.
8. Assure a diverse, adequate, and competent workforce to support the public health system.
9. Evaluate effectiveness, accessibility, and quality of personal and population – based health services.
10. Conduct research to seek new insights and innovative solutions to health problems.
11. Assure access to primary health care for all.
12. Foster the understanding and promotion of social and economic conditions that support good health.

Healthiest Wisconsin 2010, the state plan, identifies the following 5 system (infrastructure) priorities needed to build the public health capacity, to fulfill the essential services and to function effectively and efficiently to improve the health of the state population as a whole:

1. Integrated, electronic data and information systems
2. Community health improvement processes and plans
3. Coordination of state and local public health system partnerships
4. Sufficient and competent workforce
5. Equitable, adequate and stable financing

Healthiest Wisconsin 2010, the state plan, also identifies 11 health priorities which reflect, to a large extent, the underlying causes of hundreds of diseases and health conditions affecting the Wisconsin population. Health outcomes can be improved and health care costs reduced by addressing:

1. Access to primary and preventive health services
2. Adequate and appropriate nutrition
3. Alcohol and other substance use and addiction
4. Environmental and occupational health hazards
5. Existing, emerging, and re-emerging communicable diseases
6. High risk sexual behavior
7. Intentional and unintentional injuries and violence
8. Mental health and mental disorders
9. Overweight, obesity, and lack of physical activity
10. Social and economic factors that influence health
11. Tobacco use and exposure

Wisconsin's population has experienced deterioration in health status versus other states in recent years. In the annual national survey conducted by United Health Foundation, Wisconsin has dropped from 6^{th} in 1990 to 10^{th} in 2002 to 14^{th} in 2003 among states in terms of the health of the population. Wisconsin's decline in ranking is related to a decline in health outcomes, particularly lack of progress in tobacco use and infant

mortality. Wisconsin has also experienced declines in lifestyle decisions that affect health, especially factors related to obesity.

State Fiscal Context

Wisconsin state government operates on a biennial budget basis. Spending decisions and program initiatives with a fiscal impact are incorporated in the biennial budget legislation. The next biennial budget bill is the 05-07 biennial budget bill, which covers the period July 2005-June 2007. The bill will be passed by the legislature in the summer of 2005. State agencies are required to publish their proposed 05-07 agency budgets in September 2004. Due to these timing requirements, program and fiscal issues are analyzed during the spring and summer of 2004. Thus, it is timely now to consider options for a PHI in Wisconsin and the implications.

The current state fiscal condition in Wisconsin is challenging due to a weak economy and past budget decisions that created a structural deficit. While the economy is showing signs of recovery, due to constrained fiscal resources, there is strong pressure to control state spending in the 05-07 biennial budget. In addition, Governor Doyle has stated that a key objective of his Administration is to reduce significantly the number of state employees in the 05-07 biennium.

Wisconsin currently spends far less than most states on public health. In its recent survey of the 50 states, the United Health Foundation cited above notes that Wisconsin's biggest challenge is low financial support for public health care that is 35 per cent below the average state.

A significant recent fiscal development that will influence the public health system in Wisconsin is the designation of the Blue Cross/Blue Shield conversion funding for public health purposes. In March 2000 the State Insurance Commissioner approved the conversion of Blue Cross & Blue Shield of United of Wisconsin to a for profit stock corporation under the following conditions. The proceeds from the conversion are divided equally between the University of Wisconsin Medical School and the Medical College of Wisconsin to be spent as follows: 35% must be directed toward improving public health in Wisconsin and the remaining 65% may be used for medical research and health care provider education. As of March 2004 the UW Medical School and the Medical College of Wisconsin had each received a total of approximately $300 million in proceeds. Each school has established a structure and a process for awarding the 35% of the funds designated for public health that is directly linked to the priorities in the state health plan. The Blue Cross/Blue Shield conversion funding represents a significant infusion of new revenue into the Wisconsin public health system.

Committee Report

On February 26, 2004, DHFS Secretary Helene Nelson created a committee to examine the issues related to a Wisconsin Public Health Institute. The Committee was charged

with: "preparing a concept paper to lay out the issues and develop the pros and cons for a Wisconsin Public Health Institute". The Committee was directed to examine two possible structures for a Wisconsin PHI:

1. A 501(c)(3) not-for-profit organization

2. A state public authority

These two structures can result in a reduction of the number of state positions. Since positions at the University of Wisconsin (UW) are state positions, the structural option of creating a PHI based at the UW was not included for consideration.

The Committee was charged with completing its work within a two-month period. This timeframe was chosen to provide time for analysis and subsequent consultation with external public health partners within the timeframe of the preparation of the agency and Governor's 05-07 biennial budget plan. If the Administration decides to support the creation of a PHI, the authorization and appropriate statutory, funding, and position changes could be included in the 05-07 biennial budget bill. Alternatively, the establishment of a PHI could be considered as a separate bill. This committee report is designed to facilitate a well-informed discussion of the options before the state.

This report is organized in the following manner. Key issues for consideration are identified. For each issue background information is provided, followed by Committee recommendations related to the issue area. Following the sections discussing issues for consideration is an analysis of the pros and cons of the alternative models.

Wisconsin State Public Authorities

Wisconsin state authorities are public, corporate bodies created for specific purposes. Wisconsin currently has five state public authorities: the University of Wisconsin (UW) Hospitals and Clinics Authority, the Wisconsin Housing and Economic Development Authority (WHEDA), the Wisconsin Health and Educational Facilities Authority, the Fox River Navigational Authority, and the World Dairy Center Authority. These are quasi-governmental entities that have more flexibility than state governmental agencies because they are not subject to state hiring, procurement and contract requirements or the state budget process.

Of the five authorities, the two largest authorities are the UW Hospital Authority, created in July 1996, and the WHEDA established in July 1973. For this reason, the Committee focussed its attention on UW Hospital and WHEDA. Both authorities are governed by a board of directors, which is responsible for all management decisions, including setting the budget for the authority. For each authority, the Governor appoints some of the governing board members. The Governor appoints the head of WHEDA, the Executive Director, subject to the consent of the Senate, for a 2-year term. The UW Hospital

governing board appoints the Chief Executive Officer of UW Hospital. Attachment 2 provides a summary of the governance structure of WHEDA and the UW Hospital.

ISSUES REQUIRING CONSIDERATION IN THE ESTABLISHMENT OF A WISCONSIN PUBLIC HEALTH INSTITUTE

Scope and Mission

Background: The mission and scope of an Institute can be very broad or relatively targeted. The broadest possible mission and scope would include, but not be limited to, all governmental public health functions.

The Committee identified two options as the most appropriate for consideration for the scope of a PHI, if a PHI is created in Wisconsin at this time:

(a) Targeted Scope: The PHI's scope includes some, but not all, of the essential public health services, infrastructure priorities, and health priorities in the state health plan, and the PHI assumes some of the functions and associated staff and funding currently in DHFS/ Division of Public Health (DPH) that relate to the public health essential services (e.g., as much as 90% or as little as 10%). Either the public authority or the 501(c)(3) structural model could be used.

(b) Comprehensive Scope: The PHI's scope includes all twelve essential public health services, five infrastructure priorities, and eleven health priorities articulated in the state health plan and the PHI assumes all functions, funding, and staff currently in the DHFS/DPH. This option would require using the state public authority model. The responsibilities of the PHI would include carrying out emergency public health actions in response to public health outbreaks or threats (e.g., SARS, toxin spill, anthrax, etc.).

The two scope options in conjunction with the two structural models produce three possible models, as shown in the matrix below:

	Targeted Scope	**Comprehensive Scope**
Public Authority	X	X
Non-Profit 501(c)(3)	X	Not Applicable

All of these models differ significantly from the initial formation of institutes in other states. In the states currently with PHIs, functions and the associated funding and positions were not transferred at the outset from the state health department to the PHI.

A consideration for the "targeted scope" model is the selection of the functions to be transferred from DHFS to the PHI. Depending on the functions selected to be transferred to the PHI, the creation of the PHI could create a split between: regulatory and

"traditional" public health functions (such as communicable disease) which remain at DHFS and "contemporary" public health functions (such as obesity, chronic diseases, etc.) which transfer to the PHI. The current public health philosophy is to recognize the linkages between and promote the integration of "traditional" and "contemporary" public health issues.

A key consideration for the comprehensive scope model is whether emergency public health responsibilities could be handled by a quasi-governmental agency in a way that assures that the actions needed to address public health outbreaks or threats were immediately responsive to the Governor's direction and fully integrated and coordinated with other parts of emergency state government.

Committee Recommendation regarding Mission and Scope:

- The mission of a Wisconsin PHI should be to add value to, and help transform the Wisconsin public health system as envisioned in the state health plan, *Healthiest Wisconsin 2010.*

- The Committee ranked the 12 essential health services in regard to their priority for inclusion under the "targeted scope" alternative. Attachment 3 provides a summary of the Committee's views. Based on the Committee members' individual and collective views, the Committee recommends that the highest priority essential public health services to include in the scope of a "targeted scope" PHI are:

  - conduct research to seek new insights and innovative solutions to health problems;
  - evaluate effectiveness, accessibility and quality of health services;
  - promote community partnerships to identify and solve health problems;
  - educate the public about current and emerging health issues;
  - foster the understanding and promotion of social and economic conditions that support good health;
  - monitor health status to identify health problems;
  - assure a diverse, adequate and competent workforce.

  Conversely, the Committee recommends that the following essential health services be considered very low priority or inappropriate for a PHI:

  - enforce laws and regulations that protect health and ensure safety ;

- assure access to primary care;

- link people to needed health services.

Governance and Independence

Background: There is a broad possible range of independence that the PHI can have from state government. One end of the continuum is for the PHI to be completely controlled by state government; in effect to operate as a "wholly-owned subsidiary" of state government. In this model, all governing board members are appointed by the Governor and/or are public officials (for example, the DHFS Secretary, DOA Secretary, etc.). The other end of the continuum is for the PHI to be completely independent of state government, with the ability to pursue functions and activities it determines most appropriate.

Some PHIs in other states were established at the outset as independent from state government and have continued to operate in this manner. Others were established at the outset with close ties to state government; however, over time these PHIs have become more independent of state government.

A PHI has some degree of independence from the Governor. Two implications of this are: (a) the Governor has less direct control of some state public health decisions and activities; and (b) future Administrations may curtail or eliminate the PHI if the future Administration is interested in gaining more direct control of state public health functions through the Governor's administration of a cabinet agency.

<u>Committee Recommendations regarding Governance and Independence</u>:

- The Governing Board of a PHI should have representatives from a broad range of public health partners including state agencies, local public health departments, the Medical College of Wisconsin, the UW Medical School, schools of nursing, other health professions schools, and community-based organizations. Such organizations could include Area Health Education Centers (AHECs), community health centers, and the Wisconsin Office of Rural Health. This is consistent with the recommendations of the state health plan which emphasizes that the public health system is a partnership between government, the people, and the public, private, non-profit and voluntary sectors. Members of the Governing Board should have staggered terms, with a length of at least four years to provide stability and continuity even during changes in political administrations.

- A Wisconsin PHI should initially have close ties to state government to assure close coordination between the public health functions in the PHI and those in the state health department. However, the governance structure should be designed in a way that provides the flexibility to allow the PHI to evolve into a more independent entity over time.

Public Accountability

Background: Wisconsin Open Records Laws, which apply to state entities, require that certain procedures and standards be followed in responding to a request for record access. The Wisconsin Open Meetings Law requires that a meeting of a "governmental body" be announced. To promote public accountability, the authorizing legislation for the UW Hospital Authority requires that the UW Hospital be subject to the open records and meetings laws, and provide the Legislative Audit and Fiscal Bureaus and the Department of Administration access to its financial records. The authorizing legislation for the PHI could specify these same requirements for the PHI for either structural model.

Committee Recommendation regarding Accountability:

- The public health system involves a broad set of public and private partners and stakeholder groups. Close communication and collaboration among the public health entities is critical to maintaining an effective public health system. It is in the public interest to have public health discussions and deliberations be as transparent as possible. For this reason, the PHI should be subject to the open records and meetings laws, and be required to provide the Legislative Audit and Fiscal Bureaus and the Department of Administration access to the financial records of the PHI, especially if the scope of the PHI is broad. This is similar to the treatment of the UW Hospital Authority.

Funding

Background: The budget for the DHFS Division of Public Health for State Fiscal Year 2005 is $183,231,800 All Funds. The type and source of funding is shown in the summary table below.

DHFS Division of Public Health
SFY05 Budget

	General Purpose Revenue-GPR	*Federal, Program Revenue and other funds*	*All Funds*
State Operations (% of total funding)	$4,382,000 (2.4%)	$38,931,400 (21.2%)	$43,313,400 (23.6%)
Local Assistance/Aids (% of total funding)	$29,974,000 (16.4%)	$109,944,400 (60%)	$139,918,400 (76.4%)
Total (% of total funding)	$34,356,000 (18.8%)	$148,875,800 (81.2%)	$183,231,800 (100%)

The public health system in Wisconsin utilizes federal and private foundation funding to a significant degree. DHFS/DPH currently administers 86 external grants. (See Attachment 4 for list of grants.) Certain federal grants, particularly block grants such as the Maternal and Child Health Block Grant and the Preventive Health and Health Services Block Grant, can be awarded only to state governmental entities. In general, both public and private organizations are eligible for competitive grants issued by the federal government. Similarly the major private health-oriented foundations, such as Robert Wood Johnson and Helen Bader, permit both public and private organizations to compete for their grants. Some smaller foundations award grants only to non-governmental entities.

The current policy applied to state agencies to avoid increasing the net number of state positions is constraining DHFS/DPH's ability to pursue federal and external grants. In many cases new positions, funded with the grant revenue, are needed to carry out the grant requirements.

According to national experts at the National Network of Public Health Institutes, the experience in other states has been that the PHIs have brought in net additional revenues to the state public health system. The institutes are not hindered in their pursuit of grants by the constraints in hiring, purchasing, and contracting that apply to state agencies and have been very "entrepreneurial" and aggressive in seeking external funding. PHIs in other states have found the most significant fiscal challenge is in securing some "core" infrastructure funding for administration and development and other infrastructure needs, especially in the initial years. At least three of the institutes in other states have received some funding from the state's Blue Cross/Blue Shield conversion funding foundation.

<u>Committee Recommendations regarding Funding</u>:

- Under either structural model, for those functions transferred from DHFS or other state agencies to the PHI, the associated funding should transfer on a permanent basis to the PHI regardless of the funding source. Specifically, in cases where a transferred program includes GPR funding, the GPR funding would transfer to the PHI.

- Funding should not be cut as a result of the transfer of functions from DHFS or other state agencies to the PHI so that funding for the public health system as a whole does not decrease due to the creation of a PHI.

- All funding for a function should be transferred, including the federal indirect cost funding and other funding currently used to finance department or state administrative support. As a result, DHFS will need to reduce central administrative support functions; and reallocate central administrative costs to the remaining programs in the Department to the extent that it is not possible to reduce central administrative functions by the full amount of the funding transferred.

- The PHI should be a vehicle for capturing untapped external funding which would infuse additional funding into the public health system.

- It is important that the PHI have core funding, especially in its start-up period. This core funding would be in addition to the program-related funding that would be transferred to the PHI on a permanent basis.

Human Resources

Background: There are 403.82 FTE in the DHFS/DPH in SFY05. All of the DHFS/DPH positions are state positions and are included in the state "position count".

State public authorities can be structured such that the positions are or are not state positions. None of the positions in the Wisconsin Housing and Economic Development Authority (WHEDA) are state positions and therefore none are included in the state "position count". In contrast, the UW Hospital Authority has a hybrid human resources structure in which some positions are state positions and are included in the state position count and other positions are not. If a 501(c)(3) structural model is used for a PHI, none of the positions are state positions and therefore none are included in the state "position count".

Both WHEDA and the UW Hospital Authority participate in the Wisconsin Retirement System (WRS) and its associated benefits programs. To require a non-profit 501(c)(3) PHI to participate in the WRS system, changes in other Wisconsin statutes (Chapter 40) are needed and certain federal conditions (in Chapter 26 of the US Code) must be met. If the state public authority structural model is used, the PHI could be required to participate in WRS as part of the authorizing legislation and no other statutory changes would be needed.

As part of the terms of its creation, the UW Hospital Authority had a one-year "transition" period in its first year during which employees transferred into the new authority retained compensation, procedural, and other rights.

Of the total 403.82 DHFS/DPH positions, 81% are represented and 19% are non-represented. The represented positions are in seven different state unions. The transfer and/or reduction of current state employees could affect the bargaining agreements and the membership base of the state labor unions. Given that 81% of all current DPH positions are represented, it is highly likely that a portion of the state positions transferred and/or reduced as a result of the establishment of the PHI will be represented positions. At the UW Hospital Authority, those positions that remained state positions maintained membership in the same state union. However, with each union, the UW Hospital Authority negotiates a bargaining agreement that is distinct from the state bargaining agreement with that union. The UW Hospital's labor agreements with these state unions are not subject to legislative review or approval. For those UW Hospital positions that were represented state positions prior to the transfer but were no longer state positions

after the transfer, the UW Hospital Authority enabling legislation provided the employees the right of collective bargaining and the right to choose union representation after the one-year transition period. These employees chose to maintain representation by the same state union after the transition period.

After the transition period, or immediately if there is no transition period, the PHI would not be subject to state hiring, promotion, and salary requirements. The PHI would determine the number of employees; their qualifications and duties; and their compensation. As a result, the PHI could change the size and mix of positions over time to reflect its portfolio of activities and needs.

Committee Recommendations regarding Human Resources:

- If the state authority structure is adopted, the WHEDA model is the least complicated, with none of the positions as state employees and therefore none of the positions included in the state "position count". This approach supports the Governor's goal of downsizing state positions. Under this version of a public authority or the non-profit 501(c)(3) structure, establishment of a PHI will decrease state positions to the extent that existing functions are transferred from DHFS/DPH to the Public Health Institute.

- Currently, in a number of areas, the DPH contracts with the University of Wisconsin to hire individuals to work on DPH projects. These individuals are UW-Madison employees, but are carrying out the same types of responsibilities as DPH employees. If the associated function is transferred to a PHI, these contracted employees could transfer to the PHI, resulting in a decrease in state position count at UW-Madison.

- It is possible that other public health-related positions at UW-Madison and other state agencies could also be transferred to the PHI, further reducing the number of state positions.

- In cases where a position is transferred to the PHI from DHFS or another state agency, the position, whether filled or vacant, would be transferred on a permanent basis; (that is, the PHI would retain the position and associated funding for positions that are initially filled but then vacated by the incumbent.)

- If the state public authority model is used and state employees are transferred to the PHI, there should be a "transition" period of one year or longer during which the bargaining representation, compensation, benefits, and procedural guarantees of transferred employees would not be altered. Transition period procedural guarantees would include the right of employees transferred to the PHI to transfer to positions in DHFS or other state agencies subject to state bargaining agreements and personnel rules. This approach mirrors the experience of the UW Hospital Authority.

- Under either structural model, the PHI should be required to participate in the Wisconsin Retirement System (WRS) and its associated benefits programs to provide transferred employees continued access to the same health, retirement, and other benefits. (As noted above, this will require more extensive statutory changes under the non-profit 501(c)(3) structural model.)

- Under either structural model, the PHI should be provided the flexibility to have a limited number of DHFS or other state employees work in the PHI for limited periods of time (for example up to five years), while allowing the state employee to retain all of his/her state employee rights and status. This arrangement would be used in cases where close collaboration between the PHI, DHFS, and other state agencies is critical to successful implementation of a project.

Relationships with Other Entities

Background: DHFS/DPH has a network of partnerships and contractual relationships to carry out its public health responsibilities.

As noted above, under any of the models, the PHI will have direct responsibility and the associated funding for certain functions. In addition, DHFS could choose to contract with the PHI based on the PHI's expertise for specific activities that remain DHFS responsibilities. This is very typical in states that have institutes. Based on its expertise, the PHI could also develop contractual relationships with public health or other entities to carry out specific activities.

For those functions which are transferred to the PHI and for which the PHI has direct responsibility, the PHI could choose to carry out the functions with its own staff or could contract with other entities for specified activities, if it determines that contracting out is more cost effective or appropriate. Some of the functions transferred to the PHI from DPH may be functions for which DPH currently contracts with outside partners. In these cases, it is possible that the PHI could choose to carry out the functions directly with its own staff, causing the outside entity to discontinue these activities and lose the associated funding.

Recent legislation, 2003 Act 186, requires the establishment of a broad-based 23-member Public Health Council in DHFS to advise DHFS, the governor, the legislature, and the public on progress in implementing the 10-year public health plan and coordination of responses to public health emergencies. If a PHI is created, the relationship of the Public Health Council to the new PHI will need to be determined.

The possibility exists for competition between the PHI and other public health entities; for example, the PHI could compete for the same external grant as DHFS, one of the medical schools, or a community-based organization. According to national experts, the experience in other states has been that the PHI has not engaged in harmful competition with the other public health entities in the state. In general the PHIs in other states have

developed partnerships and collaborative relationships with other entities. One tool that has facilitated this collaboration is the participation on the institute Governing Board of the Director of the state health department.

Further analysis would need to be undertaken to determine whether local public health departments could have the same relationships with a public authority as they currently do with a state agency.

Another issue affecting the PHI's relationship to other entities is the physical location of the PHI. In particular, housing the PHI in the same building as DHFS would facilitate coordination between the PHI and the programs remaining in DHFS. Conversely, locating the PHI in a separate building, and possibly in a city other than Madison, could diminish the ease of coordination between the PHI and the rest of DHFS.

Committee Recommendations regarding Relationships with Other Entities:

- There should be strong collaboration between the PHI and other public health partners, including DHFS, local public health departments, community-based organizations, academic institutions, and other entities.

- The Governing Board should be designed to help minimize unnecessary and wasteful competition. Other mechanisms should be used to dampen competition and to promote collaboration.

Statutory Provisions

Background: The statutory responsibilities for Health, Administration, and Supervision of the Public Health System are specified in Wis. Stats. 250. Chapter 251 defines the requirements of establishing local health departments, establishing local boards of health and their duties, and defines the levels of service and duties of local health departments. Programmatic public health responsibilities for DHFS are specified in Chapters 252 (Communicable Diseases), 253 (Maternal and Child Health), 254 (Environmental Health), 255 (Chronic Disease and Injuries), 146 (Miscellaneous), and 160 (Groundwater Protection). Relative to other states, Wisconsin is considered to have strong public health statutes because the state laws are comprehensive, include core functions, and have been updated in the past decade.

Establishment of a PHI will involve changes to the public health statutes, particularly regarding responsibilities currently assigned to DHFS that are transferred to, or become joint responsibilities with the PHI.

The Legislative Reference Bureau, the Administration, and the Wisconsin Public Health Association are in the process of reviewing Wisconsin public health statutes to determine how they compare with the national model law as part of the National Turning Point

Public Health Law Modernization Collaboration. Any statutory changes related to a PHI will need to be consistent with the public health statute revision process.

Committee Recommendation regarding Statutory Provisions

- Any statutory changes to establish a PHI and specify its responsibilities should be crafted in a way that does not erode Wisconsin's current strong statutory basis for public health and that supports the vision of the state health plan.

Confidentiality

Background: The federal Health Insurance Portability and Accountability Act (HIPAA) has resulted in issuance of federal regulations concerning privacy and security of individually identifiable health information. DHFS/DPH frequently has a need to obtain records from health care providers who are controlled by HIPAA. HIPAA privacy regulations allow health care providers to provide a "public health authority", such as the DHFS/DPH, with record access without patient consent under certain circumstances, including public health surveillance, public health investigations, and public health interventions. The state statutes that create a PHI could specify that the PHI is a "public health authority", as defined in federal HIPAA regulations, thereby providing the PHI the authority to obtain patient health records from health care providers without patient consent if needed for public health surveillance, investigation, or intervention, if such activities are included in the PHI statutes.

In addition to HIPAA, Wisconsin state statutes address access to patient records, both in broad patient health care records statutes and in the context of particular health activities. For example, there are statutes concerning reporting of communicable disease, confidentiality of HIV test results, sexually transmitted diseases, birth defect prevention and surveillance, and congenital testing of newborns. In general, these state statutes provide DPH access to patient records in these areas without patient consent under certain circumstances. The state statutes that create a PHI could specify that the PHI has access to patient records in these areas without patient consent under the same circumstances, if it is determined that such access is consistent with the PHI's responsibilities.

Copyright and other Intellectual Property Issues

State government can copyright materials or can obtain trademarks or patents. In most of state government the practice is to allow maximum possible public access to materials created with state funds. If the PHI is allowed to obtain copyrights, trademarks and/or patents, statutory provisions could be adopted to specify the terms on which such material would be available to DHFS and other parties, especially materials and documents that are currently in the public domain.

Pros and Cons of Alternative Models

This section presents pros and cons of the alternative models.

Option A. Public Authority with comprehensive scope that assumes all functions in the DHFS Division of Public Health.

Option B. Public Authority with targeted scope that assumes some functions in the DHFS Division of Public Health.

Option C. Nonprofit 501(c)(3) corporation with targeted scope that assumes some functions in the DHFS Division of Public Health.

Option D. The status quo: the Division of Public Health is maintained intact as part of DHFS as it exists in May 2004 and a PHI is not created at this time.

Pros of Options A - D	***A***	***B***	***C***	***D***
Pros				
1. The PHI will be able to operate with more flexibility than the current Division of Public Health, enabling it to pursue funding, create positions, conclude contractual and procurement relationships in ways that advance the public health goals of the state without the constraints applied to state governmental agencies.	x	x	x	
2. It is expected that the PHI will be aggressive in seeking new external funding and would be the direct recipient of grants from the federal government and foundations. The PHI could seek those grants currently not being accessed by DHFS due to position constraints on state agencies. If successful at capturing untapped external funding, the PHI will generate a net increase in public health resources in the state.	x	x	x	
3. To the extent that functions and the associated funding currently performed by DHFS or other state agencies are transferred to the PHI, the creation of a PHI will reduce the number of state employees.	x	x	x	
4. A board governs a PHI. To the extent that the governing board includes members other than DHFS officials, this structure increases the participation of public health partners in state public health decisions.	x	x	x	

Pros of Options A - D	*A*	*B*	*C*	*D*
5. Because of its status as a quasi-governmental or non-profit agency, a PHI will be able to serve as a spokesperson and exercise leadership on public health issues in a non-partisan, research-based manner, even on controversial issues.	x	x	x	
6. The duplication of administrative functions related to state public health activities is minimized because all public health functions currently housed in DHFS/DPH remain in one entity.	x			x
7. It would be possible to transfer to the new PHI positions with the incumbents from DHFS and other state agencies. This would have the benefits of: (a) preserving job security for the existing employees whose positions are subject to transfer; (b) providing a cadre of experienced, knowledgeable staff to the PHI, enabling the PHI to assume activities immediately without a "gap" between the time DHFS ceases and the PHI begins a function.	x	x		
8. The PHI would be able to compete for foundation grants that are designated exclusively for non-governmental entities.			x	
9. The PHI will not be able to undertake new initiatives without sufficient funding. As a result, there will be a clearer recognition of the resource needs related to new initiatives of interest to the Administration or Legislature.	x	x	x	
10. No new fragmentation is created in the public health system.				x
11. No additional administrative disruption is created in the current public health system.				x
12. Because it is housed in a large department, there is some flexibility for funding and/or positions to be reallocated from other parts of the Department to the DPH to absorb new statutory or administrative requirements for which new funding has not been provided.				x
13. Coordination between DPH and the rest of DHFS and other state agencies is not disrupted.				x

Cons of Options A - D	*A*	*B*	*C*	*D*
Cons				
1. If positions in DPH are reduced as part of the Governor's initiative to reduce the state labor force, and no alternative organization is created to house the positions and carry out the functions, there will be a reduction in the state's capacity to address public health problems at a time when Wisconsin is losing ground in health outcomes versus other states.				x
2. The ability of the state government to secure new external funding will continue to be hampered due to the policy applied to state agencies to avoid increasing the net number of state positions.				x
3. There may be reluctance by legislative and administrative decision-makers and the public to place emergency responsibilities that affect the immediate safety of citizens in an entity that is not a traditional state governmental agency.	x			
4. By placing state public health functions in a quasi-governmental or non-governmental agency, there may be a perception by the public that the state is abandoning its public health responsibilities.	x	x	x	
5. This option increases fragmentation within DPH by splitting between two entities the public health functions currently integrated in one entity (DPH).		x	x	
6. This option may impact coordination between public health functions and other health and social service functions currently housed in DHFS by creating an organizational separation between the two areas. Strong relationships and mechanisms of coordination between the PHI and DHFS, similar to mechanisms currently in place between DHFS and other state agencies, could minimize or offset completely the potential deterioration in coordination.	x	x	x	
7. This option may also impact coordination between public health functions in the PHI and related public health functions in other agencies, such as the Department of Natural Resources or Department of Agriculture, Trade, and Consumer Protection, on cross-cutting issues involving multiple agencies, such as bioterrorism preparedness.	x	x	x	

Cons of Options A - D	*A*	*B*	*C*	*D*
8. Because of its quasi-governmental status and lack of formal role in the state budget or legislative process, it may be more difficult for the PHI to influence the Governor's and legislature's public health-related budget and policy decisions and initiatives.	x	x	x	
9. Due to the loss of economies of scale, the funding for support functions transferred into the PHI may not be sufficient to fund all PHI "core" activities. It is more likely that there will be a need for new funding for "core" activities than under other options.		x	x	
10. For those areas that are not statutorily mandated to be responsibilities of the PHI, the PHI could be selective about the public health activities that it pursues, with the possibility that the PHI will focus its efforts on those that are relatively more lucrative, higher visibility, less demanding, and /or that have more popular appeal (i.e., engage in "cherry-picking"). Under the models where the PHI has a targeted scope and the DHFS/DPH continues to exist, DPH would need to assume those public health functions that the PHI is unwilling to carry out. Under the model where the PHI has a comprehensive scope and the DHFS/DPH entity no longer exists, the state's public health capacity would be reduced to the extent the PHI discontinued discretionary functions now undertaken by DPH.	x	x	x	
11. The PHI would be constrained from being the direct recipient of those federal grants awarded exclusively to a state government entity. These grants would continue to be awarded to the State Department of Health and Family Services.			x	
12. It would not be possible to transfer existing incumbents from DHFS to the PHI. Under this model, state positions associated with functions that are transferred to the PHI would be cut on a permanent basis; and the existing state employees whose positions are cut would not have guaranteed access to positions in the PHI. It is possible that individuals with high levels of public health expertise would no longer be employed and utilized in the public health system. In addition there may not be a smooth transition of functions from the state to the PHI due to the lead-time involved in recruiting and hiring personnel at the PHI, resulting in, among other things, the loss of funding opportunities.			x	

Summary

This paper was written to identify the issues so that there can be an informed discussion with the public health community and policy makers about the options before the state.

A Public Health Institute (PHI) can improve, strengthen, and help transform the Wisconsin public health system. Institutes have been established or are being established in a significant number of other states. The merits of establishing a PHI in Wisconsin has been discussed for a decade.

Key challenges in the major issue areas requiring consideration include:

- Scope and Mission: the priorities defined for the PHI and the extent to which functions currently in DHFS/DPH transfer at the outset to the PHI;

- Independence and Governance: the degree of independence between the PHI and the Administration and the degree of inclusion of external public health partners on the governing board;

- Funding: the establishment of a stable source of core funding and the identification of expected sources of program and project funding;

- Human Resources: the consequences for current state public health employees and the effect on the state's "position count" ;

- Relationship to Other Entities: the establishment of mechanisms that promote a collaborative, non-competitive relationship between the PHI and other public health partners.

The tight fiscal condition of the state, and especially the pressure to downsize the state workforce, makes the establishment of a Wisconsin PHI a timely issue for consideration. However, creating a Wisconsin PHI in the current fiscal environment presents some unique challenges that were not present in other states and would not have been present in the past in Wisconsin.

List of Attachments

Attachment 1: Matrix of National Network of Public Health Institutes

Attachment 2: Governance Structure of UW Hospitals and Clinics Authority and WHEDA

Attachment 3: Priorities for the Scope of a PHI

Attachment 4: Grants Administered by the DHFS Division of Public Health

Attachment 5: Potential Criteria for Measuring Success submitted by the Wisconsin Public Health Advisory Committee

Matrix for National Network of Public Health Institutes

	Arkansas Center for Health Improvement	Public Health Institute	Colorado Foundation for Public Health and Environment	Hawaii Outcomes Institute
State of Location	AR	CA	CO	HI
Founded	1998	1964	1993	2001
Number of Employees	34	570	0	8
History of Development	Established through organizational affiliation with the University of Arkansas for Medical Sciences.	Established in 1964 as the California Public Health Foundation by state health department. Acquired programs of Western Consortium for Public Health in 1997.	Established in 1993 as an entity working closely with the Colorado Department of Public Health and Environment. Due to legislation, the close relationship was severed.	There was enabling legislation for the DOH to use a portion of the tobacco settlement dollars to start the Hawaii Outcomes Institute.
Organizational Affiliation		501c3	501c3	501c3
Board of Directors (Y/N)	16 members: Represent public and private health care providers and organizations, academia and private business	15 members: Public and Community Health Practitioners and Researchers	10 members: Eight private and two public officials comprise the Board of Directors. All are volunteers.	12 members: Represents the DOH, academia, research institutes, and community coalitions.
Scope of Work	ACHI aims to improve the health and health care of Arkansans through health policy research and development, health professional education, program development and public health advocacy. Serves as a resource to link and coordinate academic personnel, health professionals and other collaborators.	Broad/community-based, policy and research organization.	Accepts tuition on behalf of the Regional Institute for Health and Environmental Leadership. Acts as the fiscal agent for RIHEL grant from a private foundation. Focus has been on education.	Supports development of health outcomes policy. Builds statewide data warehouse for community profiles. Facilitates professional development. Builds research capacity and measures outcomes of community grant programs
Relationship to State Health Department	Arkansas Department of Health is the lead partner in the ACHI	Do not serve on board of directors but do serve as a funder.	No formal relationships.	DOH holds seats on the board of directors and is currently the primary funders.
Funding	Operational budget for 2002 is $1.4 million. Federal Grants 9%; Foundation 51%; Contracts 23%; and State Support 17%	Operational budget is $7 million. Total revenue is approximately $70 million.	Budget is approximately $ 225,000.00.	Seed money is projected to be $5 million over 3 years. Must be self-sustaining thereafter.
Infrastructure Funding		Minimal funding from the CA Wellness Foundation.	Receives no direct funding for infrastructure.	Receives all monies from DOH.
Indirect Cost Rate	20%	17.50%	3.00%	TBA

10/10/2002

Matrix for National Network of Public Health Institutes

	Public Health Futures Illinois	Kansas Health Institute	Louisiana Public Health Institute	Massachusetts Institute for Local Public Health
State of Location	IL	KS	LA	MA
Founded	1997	1995	1997	1998
Number of Employees	3+	19	10	1
History of Development	Established in 1997 by IL Dept. of Public Health (IDPH) for systems-level strategic planning and subsequently became a grantee of the RWJF Turning Point program.	Established in 1995 by the vision and funding of the Kansas Health Foundation.	Established in 1997, LPHI has been approved by concurrent resolutions in the Louisiana legislature.	Establish in 1998 by the Local Health Coordinating Council. The Commissioners of Public Health and Environment approved statements of mission and goals.
Organizational Affiliation	Affiliated with the United Way of Illinois	501c3	501c3	Affiliated with local, regional, and state governments as well as several universities.
Board of Directors (Y/N)	26 members: Represents public agencies, community coalitions, academia, faith community, and industry.	Six members: All are private citizens with no direct agency affiliation.	Twelve members: Represent State Health Department, academia, and other nonprofit organizations.	No formal Board of Directors
Scope of Work	Broadly based on public health system improvement through state and local partnership development, policy development, public education and advocacy.	Health policy and research organization aiming to disseminate information to Kansas Policy Makers.	Focuses on health policy, health information systems, applied population research and community capacity enhancement.	The mission of the Institute is to strengthen the capacities of local public health agencies through workforce education, leadership training, program research, and community education by promoting strategic alliances.
Relationship to State Health Department	DOH holds co-chair position on steering committee. Provides in-kind support.	No formal relationships. State health department has a seat on the in-state "advisory group".	Two seats on the board are held by officials at the State Health Department and one by a local health official.	The Institute receives the majority of its funding and direction from the local state health department.
Funding	Operational budget is $170k. 100% private foundation funding, and in-kind support.	Budget is $2.7 million. Private foundation grants total more than 60%.	Budget is $1.5 million. Federal, state and private foundation grants and contracts.	Operational budget is $100,000 per year. 50/50 split between the DOH and Department of Environmental Protection
Infrastructure Funding	Receives no direct funding for infrastructure.	Funded by a core grant from the Kansas Health Foundation.	Received a three year start up grant. Does not currently receive core funding.	Yes
Indirect Cost Rate	5.00% (paid to United Way)	63.00% (often not received)	TBA	N/A

10/10/2002

Matrix for National Network of Public Health Institutes

	Institute for Community Health	Maine Center for Public Health	Michigan Public Health Institute	Minnesota Institute of Public Health
State of Location	MD	ME	MI	MN
Founded	2000	1999	1989	1972
Number of Employees	2	6	170	38
History of Development	Established in 2000 as an independent not-for-profit resource to community health organizations.	Established by state legislation and authorized by the Department of Human Services.	Established in 1989 by Michigan legislature. Authorized the Department of Public Health, in conjunction with local universities, to establish a nonprofit.	Established in 1972 as a nonprofit. Includes articles of incorporation. Is currently affiliated with Blue Cross and Blue Shield.
Organizational Affiliation	501c3	501c3	501c3	501c3
Board of Directors (Y/N)	Six Members: Represents academia, voluntary sector, business and health care organizations.	22 members: Represents health care, foundations, public health agencies, academia, community coalitions and other non-profits.	12 members: 6 government appointed members and 6 university members.	13 members: 7 executives of Blue Cross and Blue Shield, and 6 community leaders.
Scope of Work	Provides technical assistance, training and policy research to small to mid-sized geo-political areas.	Community-based programs and statewide initiatives in the area of research, education/training, and policy.	Broad based community programs for over 50 funders. Programs include research, design, evaluation, health promotion, education, and training.	Health policy, public information campaigns, community-based training, research and technical assistance.
Relationship to State Health Department	Informal	Represented on Board of Directors and collaborate through state contracts.	Jointly governed by the state health department.	Client for 20 years. Not represented on Board of Directors.
Funding	Budget is $250k. Receives technical assistance contracts, membership fees and funding from foundations.	Budget is $800k. Receives contracts from State Health Department ,CDC, and private foundations.	Budget is $20 million. Includes State contracts (75%) and federal, foundation, and private grants (25%).	Budget is $4.2 million. Contracts with state, federal grants, foundation grants.
Infrastructure Funding	Receives no direct funding for infrastructure.	Receives limited direct funding for infrastructure.	Receives no direct funding for infrastructure.	Symbiotic relationship with Blue Cross and Blue Shield.
Indirect Cost Rate	15.00%	9% on administrative services 9% on all other indirect expenses	15.00% on direct services 10.00% on sub-contracts 0.00% on equipment	50.50% Represents a percentage of salary and fringe only.

10/10/2002

Matrix for National Network of Public Health Institutes

	North Carolina Institute for Public Health	New Hampshire Community Health Institute	Nevada Public Health Foundation	NYS-Community Health Institute
State of Location	NC	NH	NV	NY
Founded	1999	1995	1996	2000
Number of Employees	50	9	6	3
History of Development	Established in 1999 as an administrative unit of the School of Public Health at the University of North Carolina at Chapel Hill.	Established in 1995 by NH DHHS with a grant from RWJF.	Established in 1996 as a nonprofit. Is governed by a board of directors.	Established in 2000 by New York's Turning Point Initiative. Supported by NYS Community Health Partnership (NYSCHP).
Organizational Affiliation	North Carolina public university system	501c3	501c3	
Board of Directors (Y/N)	Advisory Board of 14 members representing state and local government, health care (public and private), business, philanthropic organizations, community groups, managed care, and academia.	No current Board of Directors. A multiple advisory board operates on a project-by-project basis.	19 members: Represent governmental public health, private industry, education and medicine.	11 members: Steering committee of NYSCHP represent, academia, state medical and health care providers, business councils and community coalitions.
Scope of Work	The mission of NCIPH is to improve the health of North Carolinians through training, technical assistance and applied research linking the resources of the School of Public Health to community needs.	Coalition building, network formation, community needs assessments, information services, training, program evaluation, and services research.	Generates awareness of public health issues and creates partnerships to address unmet public health needs.	Coalition capacity building provides training, technical assistance, mobilizing partnerships, access to data and needs assessment.
Relationship to State Health Department	State health department is a frequent partner and/or client.	Relationship is based on grants and contracts. Offers fiscal and staffing flexibility.	Membership on board of directors.	Membership on board of directors. Is Co-lead agency with Cornell University.
Funding	Funding comes from Federal grants, foundations, contracts, receipts (from continuing education programs), and the State of North Carolina.	Budget is $2.0 million. Federal funding (50%), state and private foundation grants (40%), and contracts with CBO's.	Budget is $425k. Funding from federal, state, and private foundation grants.	Budget is $500,000 over a four-year term.
Infrastructure Funding	Core funding comes from the School of Public Health and a private foundation.	Receives no direct funding for infrastructure.	Receives no direct funding for infrastructure.	In-kind support from NYSDOH and Cornell.
Indirect Cost Rate	8%-45.5% (following university guidlines)	9.00%	15.00%	9.00%

10/10/2002

Matrix for National Network of Public Health Institutes

	Rhode Island Public Health Foundation	Virginia Center for Healthy Communities	Wisconsin- Center for Urban Population	
State of Location	RI	VA	WI	
Founded	1993	2000	2001	
Number of Employees	5	4	9	
History of Development	Established in 1993 as a nonprofit by the Department of Health., pursuant to authorizing legislation.	Establish in 2000 by Virginia State Turning Point initiative. Supported by State legislation.	Established in 2001 after a 2-year convening process between two universities and a health care system.	
Organizational Affiliation	501c3	501c3	Affiliated with U. Wisconsin Medical School, UW-Milwaukee, and Aurora Health Care	
Board of Directors (Y/N)	12 members: Represent state agencies, private businesses, academia, health care providers, and social service providers.	Boards of Trustees include representatives from public (50%) and private institutions (50%).	10 member board drawn from partner organization and at-large community representatives	
Scope of Work	Aims to solve community health problems, strengthen public health infrastructure, and serve as a fiscal agent in joint projects.	Seeks to advocate disease prevention, conduct formative research, and foster partnership development that engages businesses in community health improvement initiatives.	CUPH seeks to improve individual and population health through health services research, evaluations, professional education, and health promotion programming.	
Relationship to State Health Department	Most projects are conducted in conjunction with State Dept. of Health.	State Health Commissioner sits on the Board of Trustees.	No formal relationship beyond contracted work on specific projects.	
Funding	Budget is $1.0 million. Federal funding (60%), state and foundation grants (30%), and private contributions (10%).	Has not developed a separate operating budget. Services are "in-kind".	Budget is $1.0 million through contribution of partner organizations and contracts for services.	
Infrastructure Funding	Receives no legislative appropriation, has no endowment. All infrastructure covered by indirect cost rate.	100% of operating expenses are covered by a private foundation grant.	Seed money comes from partner organizations and convening hosts.	
Indirect Cost Rate	33% (often not received)	Indirect cost rate has not been established.	10%-45%. Range is dependant upon the negotiated rate.	

Attachment 2

GOVERNANCE STRUCTURES OF UW HOSPITAL AND
WISCONSIN HOUSING AND ECONIMIC DEVELOPMENT AUTHORITY (WHEDA)

	UW Hospital	**WHEDA**
Size of Governing Board	13 voting members; 2 non-voting members	12 members
Length of Term of Board Members	3-year term for public members appointed by the Governor	Staggered, 4-year terms for public members appointed by the Governor
Composition and Appointment of Board Members	<u>Voting Members</u> ➢ 3 public members appointed by Governor, with Senate consent; ➢ DOA Secretary (or his/her designee); ➢ Co-Chairs of Joint Finance Committee (or their designees); ➢ 3 members of UW Board of Regents appointed by the Board of Regents; ➢ UW-Madison chancellor; ➢ UW-Madison Medical School dean; ➢ UW-Madison Medical School department chair, appointed by the chancellor; ➢ UW-Madison health professions school faculty member, appointed by the chancellor <u>Non-Voting Members</u> ➢ 2 representatives of labor organizations, appointed by the Governor	➢ 6 public members appointed by Governor, with Senate consent; ➢ DOA Secretary (or his/her designee); ➢ Commerce Secretary (or his/her designee); ➢ One senator and representative from each political party, appointed by legislative leadership
Appointment Authority for Chief Executive Officer of Organization	Chief Executive Officer appointed by Governing Board	Executive Director appointed by Governor, with Senate consent, for 2-year term

Attachment 3

Priorities for the Scope of a Public Health Institute
Ranking by Committee Members
March 2004

Essential Public Health Services	Pattern	Average Score (Scale = 1-10 10 – highest)
1. Monitor health status to identify health problems	Consistently High	7.8
2. Identify, investigate, control and prevent health problems and environmental health hazards in the community.		4.7
3. Educate the public about current and emerging health issues.	Consistently High	7.9
4. Promote community partnerships to identify and solve health problems.	Consistently High	8.2
5. Create policies and plans that support individual and state efforts.		4.3
6. Enforce laws and regulations that protect health and ensure safety.	Consistently Low	0.7
7. Link people to needed health services.	Consistently Low	2.6
8. Assure a diverse, adequate and competent workforce.	Consistently High	7.3
9. Evaluate effectiveness, accessibility and quality of health services.	Consistently Very High	8.9
10. Conduct research to seek new insights and innovative solutions to health problems.	Consistently Very High	9.4
11. Assure access to primary care.	Consistently Low	1.7
12. Foster the understanding and promotion of social and economic conditions that support good health.	Consistently High	7.9

Department of Health and Family Services
Division of Public Health
Summary of New and Continuation Grant Applications
Calendar Year 2003

Division	Grant Title	Granting Source	Type of Grant	Amount Requested Applied For	Amount Requested Modified	Period of Funding From:	Period of Funding To:	Federal Award #	Award Received Date	Award Received $ Amount
DPH	Special Supplemental Nutrition Program for Women, Infants, & Children (WIC)	USDA	Continuation - Unchanged	$ 61,198,335		10/1/03	9/30/04			
DPH	Public Health Preparedness and Response to Bioterrorism	DHHS	Continuation - Modified		$ 18,586,482	8/31/03	8/30/04	U90 / CCU517002-04	8/28/03	$ 18,586,482
DPH	Public Health Preparedness and Response to Bioterrorism	DHHS	Continuation - Modified Carry Over Request-FFY 03		$ 1,683,552	8/31/03	8/30/04			
DPH	Title V Maternal and Child Health Block Grant	DHHS	Continuation - Modified		$ 11,603,758	10/1/03	9/30/04			
DPH	Hospital Bioterrorism Preparedness Program	DHHS	Continuation - Modified	$ 9,180,277		9/1/03	8/31/04	2 U3RMC00017-02-00 6 U3RMC00017-02-02	9/12/03 12/18/03	$ 9,180,277 $ 9,340,539
DPH	Immunization & Vaccines for Children	DHHS	Continuation - Modified		$ 2,153,468 $ 3,247,471	1/1/03 1/1/03	12/31/03 12/31/03	H23 / CCH522563-01 H23 / CCH522563-01-2	12/26/02 5/14/03	$ 1,454,273 $ 1,861,086
DPH	Immunization & Vaccines for Children	DHHS	Continuation - Modified Unobligated Funds from Year 12		$ 43,727	1/1/02	12/31/03	H23 / CCH504480-12-6	5/5/03	$ 43,727
DPH	Immunization & Vaccines for Children	DHHS	Continuation - Modified Supplemental Award		$ 37,287	10/1/03	12/31/03	H23 / CCH522563-01-5	11/4/03	$ 37,287
DPH	Ryan White Comprehensive AIDS Resources Emergency (CARE)	DHHS	Continuation - Unchanged	$ 3,522,828 $ 1,767,870		4/1/03	3/31/04			
DPH	Ryan White Comprehensive AIDS Resources Emergency (CARE)	DHHS	Continuation - Modified Carry Over Request from FFY02 to FFY03		$ 725,169	4/1/03	3/31/04			
DPH	HIV Prevention Cooperative Agreement	DHHS	Continuation - Unchanged	$ 1,053,926 $ 2,744,090		1/1/03	12/31/03	U62 / CCU502007-18-1	4/14/03	$ 3,798,016
DPH	HIV Prevention Cooperative Agreement	DHHS	Continuation - Modified Unobligated Fund Request		$ 192,557	1/1/03	12/31/03			
DPH	Cancer Prevention and Control Program	DHHS	Amendment to Current Grant Budget Revision	$ 3,151,995		6/30/03	6/29/04			
DPH	Cancer Prevention and Control Program	DHHS	Continuation - Modified Carry Over from Year 1 to Year 2		$ 47,402	6/30/03	6/29/04			
DPH	Prevention Health & Health Services Block Grant	DHHS	Continuation - Unchanged	$ 1,509,710 $ 1,169,188		10/1/02	9/30/04	2003-B1-WI-PRVS-01 2003-B1-WI-PRVS-03	2/24/03 7/7/03	$ 2,678,898 $ 2,678,898
DPH	Bioterrorism Hospital Preparedness Program	DHHS	New	$ 2,327,920		4/1/02	3/31/04	6 U3R MC 00017-01-03	12/16/02	$ 2,327,920
DPH	Endocrine Disruptive Chemicals and Thyroid Outcomes	EPA	New revised to 4-year project	$ 128,043 $ 2,160,165		3/1/03	2/28/07	RD-83025401-0 RD-83025401-1	4/1/03 6/24/03	$ 743,710 $ 662,018

Department of Health and Family Services
Division of Public Health
Summary of New and Continuation Grant Applications
Calendar Year 2003

Division	Grant Title	Granting Source	Type of Grant	Amount Requested Applied For	Amount Requested Modified	Period of Funding From:	Period of Funding To:	Federal Award #	Award Received Date	Award Received $ Amount
DPH	Chronic Disease Prevention & Health Promotion Programs	DHHS	New	$ 2,174,011		6/30/03	6/29/04	U58 / CCU522833-01	6/30/03	$ 3,635,144
DPH	Chronic Disease Prevention & Health Promotion Programs	DHHS	Continuation - Modified Budget Revision Between Categories		$ -	6/30/03	6/29/04			
DPH	Epidemiology and Laboratory Capacity	DHHS	Continuation - Modified	$ 721,508 $ 1,314,322		7/1/03	6/30/04	U50/CCU514391-05	6/27/03	$ 1,977,206
DPH	OSHA Laboratory Contract	Dept of Labor	Continuation - Unchanged	$ 1,834,000		10/1/03	9/30/04	E9F4-2955	9/15/03	$ 1,834,000
DPH	Childhood Lead Poisoning Prevention	DHHS	Continuation - Modified	$ 128,700 $ 1,249,521		7/1/03	6/30/04	US7 / CCU522849-01	6/27/03	$ 1,237,596
DPH	STD Cooperative Agreement	DHHS	Continuation - Unchanged	$ 581,134 $ 769,565		1/1/03	12/31/03	H25 / CCH504344 - 12 H25 / CCH504344-13-1	12/26/02 4/1/03	$ 337,675 $ 1,013,024
DPH	STD Cooperative Agreement	DHHS	Amendment To Current Grant Supplemental DA		$ 102,499	1/1/03	12/31/03	H25 / CCH504344 - 13 -2	10/29/03	$ 102,499
DPH	Advancing HIV Prevention Initiative (Contract)	DHHS	New	$ 1,068,483		9/30/03	9/29/05	200-2003-02369	9/11/03	$ 1,068,488
DPH	OSHA Consultation	Dept of Labor	Continuation - Unchanged	$ 969,000		10/1/03	9/30/04	E9F4-1955	9/24/03	$ 969,000
DPH	Tuberculosis Control Program	DHHS	Continuation - Unchanged	$ 449,600 $ 365,114		1/1/03	12/31/03	U52 / CCU500485-21-2	3/27/03	$ 507,597
DPH	Tuberculosis Epidemic Aid Assistance	DHHS	Amendment to Current Grant	$ 8,370		1/1/03	12/31/03	U52 / CCU500485-21-2	3/27/03	$ 8,370
DPH	Tuberculosis Program Supplemental Funds Outbreak Assistance Funds	DHHS	Amendment to Current Grant	$ 99,729		1/1/03	12/31/03	U52 / CCU500485-21-3	6/11/03	$ 99,729
DPH	WIC - Farmers' Market Nutrition Program	USDA	Continuation - Modified	$ 799,309		10/1/03	9/30/04			
DPH	Rape Prevention and Education	DHHS	Continuation - Unchanged	$ 116,727 $ 662,364		7/1/03	6/30/04	VF1 / CCV519925 02		$ 779,091
DPH	Assess Multifaceted Fall Prevention Intervention Strategies in Community Dwellings	DHHS	Continuation - Unchanged	$ 104,024 $ 641,101		10/1/02	9/29/04	U17 / CCU522465-02	6/25/03	$ 745,125
DPH	Systems-Based Diabetes Prevention and Control Programs	DHHS	New	$ 701,716		4/30/03	3/29/04	U32 / CCU522717-01	5/5/03	$ 701,716
DPH	National Environmental Public Health Tracking System	DHHS	Continuation - Unchanged	$ 657,991		9/30/03	9/29/04	U50 / CCU522439-01		
DPH	Building State Capacity to Conduct Health Assessments	DHHS	Continuation - Modified		$ 456,710	9/30/03	9/29/04	U50 / ATU500005-16	8/20/03	$ 456,710

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DPH	Commodity Supplemental Food Program	USDA	Continuation - Modified		$ 450,537	10/1/03	9/30/04			
DPH	AIDS/HIV Surveillance Cooperative Agreement	DHHS	Continuation - Modified non-competitive continuation		$ 425,847	1/1/03	12/31/03			
DPH	AIDS/HIV Surveillance Cooperative Agreement	DHHS	Continuation - Unchanged 90 Day Extension	$ 123,279		1/1/04	3/31/04			
DPH	American Legacy Foundation Cooperative Agreement	American Legacy Foundation	New	$ 400,000		9/1/03	6/30/04			
DPH	Environmental and Health Effect Tracking	DHHS	New	$ 352,290		9/15/03	9/14/04	U50 / CCU523286-01	9/15/03	$ 352,290
DPH	State Cardiovascular Health Programs	DHHS	Continuation - Modified		$ 350,000	6/30/03	6/29/04	U50 / CCU521340-02	6/17/03	$ 350,000
DPH	State Cardiovascular Health Programs	DHHS	Continuation - Modified Carry Over From Year 1 to Year 2		$ 26,544	6/30/03	6/29/04	U50 / CCU521340-02-1	12/17/03	$ 26,544
DPH	Lead Accreditation, Certification and Enforcement Program	EPA	Continuation - Modified		$ 333,307	10/1/03	9/30/04	PB-97580303-0	9/19/03	$ 333,307
DPH	Radiological Emergency Preparedness Program - Cooperative Agreement	WI Dept of Military Affairs	Continuation - Unchanged	$ 331,075		7/1/03	6/30/04	N/A	7/2/03	$ 331,075
DPH	WIC Special Infrastructure Grant Purchase Hardware and Printers	USDA	New	$ 150,000		1/15/03	9/30/04		5/20/03	$ 150,000
DPH	WIC Special Infrastructure Grant Supplemental Funds: Infrastructure project	USDA	New	$ 132,840		1/15/03	9/30/04		10/27/03	$ 132,840
DPH	Building Environmental Health Services Capacity in State & Local Dept of Public	DHHS	Continuation - Unchanged	$ 261,794		9/30/03	9/29/04	U38 / CCU520417-02		
DPH	Addressing Asthma From A Public Health Perspective Developing State Capacity	DHHS	Continuation - Unchanged	$ 245,108		9/30/03	9/29/04	U59 / CCU520846-02	5/28/03	$ 245,108
DPH	Addressing Asthma From A Public Health Perspective Developing State Capacity	DHHS	Continuation - Modified Carry Over Request-Year 2 to 3		$ 10,500	9/30/03	9/29/04	U59 / CCU520846-03	8/13/03	$ 10,500
DPH	Indoor Radon Outreach Program Activities	EPA	Continuation - Unchanged	$ 243,070		6/1/03	5/31/04	K199501114-0	5/23/03	$ 243,070
DPH	Rural Access to Emergency Devices	DHHS	Continuation - Unchanged	$ 241,006		9/1/03	8/31/04	1 H3DRH01219-01-00	9/5/03	$ 241,006
DPH	Rural Access to Emergency Devices	DHHS	Continuation - Modified Carry Over From Year 1 to Year 3		$ 10,328	9/1/03	8/31/04			
DPH	Development of the National Violent Death Reporting System	DHHS	New	$ 235,772		8/15/03	8/14/04	U17 / CCU523099-01	8/13/03	$ 235,772
DPH	Occupational Safety & Health Training Program for Wisconsin Minority Youth	DHHS	New	$ 228,520		7/30/03	7/29/04			

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DPH	Mammography Quality Standards Act (MQSA) Mammography Inspections	US FDA	Continuation - Unchanged	$ 213,677		7/1/03	6/30/04	223-03-4449	7/1/03	$ 188,393
DPH	Health Assessment of Great Lakes Sport Fish Consumption	DHHS	Continuation - Unchanged	$ 86,723 $ 125,989		9/30/03	9/29/04	H75 / ATH598322-12	8/20/03	$ 147,646
DPH	Epidemiology and Laboratory Capacity West Nile Virus Surveillance and Response	DHHS	Amendment to Current Grant Supplemental Funding	$ 200,000		7/1/03	6/30/04			
DPH	Epidemiology and Laboratory Capacity SARS Surveillance and Response Activities	DHHS	Amendment to Current Grant Supplemental Funding	$ 229,608		7/1/03	6/30/04			
DPH	National Environmental Public Health Tracking System	DHHS	Amendment to Current Grant Unobligated Funds - FFY03 to 04		$ 200,058	9/30/03	9/29/04	U50 / CCU522439-02-01	9/22/03	$ 200,058
DPH	Basic Emergency Lifesaving Skills	DHHS	Continuation - Modified 1 Year Extension		$ 112,000 $ 88,000	2/28/03	2/28/04	1 U3RMC00017/01	3/1/02	$ 200,000
DPH	Basic Emergency Lifesaving Skills In School EMS Targeted Issues Grant	DHHS	Continuation - Unchanged	$ 105,332 $ 94,668		3/1/03	2/28/04			
DPH	Basic Emergency Lifesaving Skills in School EMS Target Issues Grant	DHHS	Continuation - Modified Carry Over Request		$ 88,505	3/1/03	2/28/04	6 H34MC00123-02-01	9/17/03	$ 88,505
DPH	MOU - Providing Certified Lead Risk Assessor Services	WI - DOA	New	$ 197,697		1/1/03	12/31/04			
DPH	Population-Based Birth Defects Surveillance Programs	DHHS	New	$ 194,000		9/1/03	8/31/04			
DPH	Exposure to Tremolite Asbestos in Vermiculite Ore	DHHS	New	$ 176,000		9/15/03	9/14/04	U61 / ATU573213-01	9/8/03	$ 176,000
DPH	Homeland Security Grant Program Equipment for State Agencies	WI - OJA	New	$ 170,906		5/1/03	10/31/04	HZ-03-ST-0077	9/29/03	$ 170,906
DPH	Assessment of Mercury Exposure in WI	WI Focus On Energy	New	$ 160,017		5/15/03	6/30/05	03 005	5/13/03	$ 160,017
DPH	SOLEC Mercury Grant WIC Clinic Fish Consumption	EPA	Continuation - Unchanged 1 Year No Cost Extension		$ 156,906	10/1/01	9/30/04	GL97571801-1	10/16/03	$ 156,906
DPH	Minority HIV/AIDS Demonstration Grant	DHHS	Continuation - Unchanged	$ 55,000 $ 95,000		9/30/03	9/29/04			
DPH	Early Hearing Detection and Intervention Tracking Referral & Coordination WE-TRAC	DHHS	Continuation - Unchanged	$ 148,000		9/1/03	8/31/04	UR3 / CCU520047-03	7/22/03	$ 148,000
DPH	Primary Care Office Cooperative Agreement	DHHS	Continuation - Unchanged	$ 130,811		7/1/03	3/31/04	5 U68 CS 00228-16-0	6/25/03	$ 98,108
DPH	School Health Programs - Improving the Health, Education & Well-being of Young People	WI - DPI	Continuation - Modified Continuing MOU from DPI		$ 122,830	3/1/03	2/28/04			

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DPH	Pre-Renovation Education Program Development	EPA	New	$ 111,835		10/1/02	9/30/05	X00582101	9/19/02	$ 111,835
DPH	Universal Newborn Hearing Screening	DHHS	Continuation - Unchanged	$ 107,928		3/31/03	3/30/04	5 H61 MC 00024-04	3/26/03	$ 107,928
DPH	Fatality Assessment & Control Evaluation (FACE)	DHHS	Continuation - Unchanged	$ 104,216		9/1/03	8/31/04	U60 / CCU507081-13	7/25/03	$ 104,216
DPH	Fatality Assessment & Control Evaluation (FACE)	DHHS	Continuation - Modified Carry Over From FFY03 to FFY04		$ 37,480	9/1/03	8/31/04	U60 / CCU507081-13-2	10/1/03	$ 37,480
DPH	Lead Identification Research and Enforcement	EPA	New	$ 100,500		2/1/02	2/1/04	X-97583201-0	1/30/02	$ 100,500
DPH	Lead Identification Research and Enforcement	EPA	Continuation - Unchanged 1 Year No Cost Extension			2/1/02	2/1/05	X-97583201-1	10/16/03	$ 100,500
DPH	State Based Birth Defects Surveillance Program	DHHS	Continuation - Unchanged Extension and Carry Forward	$ 100,500		9/1/03	8/31/04	U50 / CCU519233-03		
DPH	EMS State Partnership Demonstration	DHHS	Continuation - Unchanged Additional Authority - Unobligated	$ 100,000	$ 44,837	3/1/03 3/1/02	2/28/04 2/29/04	4 H33 MC 00097-03-02 6 H33 MC 00097-03-04	2/28/03 4/2/03	$ 100,000 $ 44,837
DPH	Early Childhood Comprehensive Systems CISS-SECSS	DHHS	New	$ 100,000		7/1/03	6/30/04	1 H25 MC 00232-01-0	7/7/03	$ 100,000
DPH	State Systems Development Initiative (SSDI)	DHHS	Continuation - Modified		$ 100,000	9/30/03	9/29/06	2 H18MC00057-11-00	9/22/03	$ 100,000
DPH	State Oral Health Collaborative Systems	DHHS	New	$ 100,000		9/1/03	8/31/04	H47MC01941	11/10/03	$ 100,000
DPH	Mercury Contaminated Sport Fish Consumption Advisory Outreach Program	EPA	New	$ 2,000 $ 83,000		10/1/02	9/30/03	X-83076801-0	10/7/02	$ 85,000
DPH	Mercury Contaminated Sport Fish Consumption Advisory Outreach Program	EPA	Continuation - Unchanged One Year No Cost Extension			10/1/02	12/31/04			
DPH	Surveillance of Hazardous Substances and Emergency Events	DHHS	Continuation - Unchanged	$ 84,478		9/30/03	9/29/04	U61 / ATU596961-13	8/20/03	$ 84,478
DPH	Domestic Preparedness Program Sub-Grant Purchase of Medication Training Kits and Medication	WI-Office of Justice Preparedness	New	$ 82,228		10/15/03	12/31/03		10/13/03	$ 82,228
DPH	Core Injury Program Development and Injury Surveillance Development	DHHS	Continuation - Unchanged	$ 75,000		9/30/03	9/29/04	U17 / CCU519383-04	9/13/03	$ 75,000
DPH	Domestic Radiological Preparedness Sub Grant Agreement	WI Dept of Military Affairs	New	$ 53,000		9/15/03	12/31/03			
DPH	Violence Against Women Planning and Implementation	DHHS	New	$ 50,000		10/1/02	9/30/03	U17 / CCU522236-01	9/16/02	$ 50,000

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DPH	Violence Against Women Planning and Implementation	DHHS	Continuation - Unchanged 90 Day No Cost Extension			10/1/02	12/31/03	U17 / CCU522236-01-1	9/25/03	$ 50,000
DPH	State-Based Occupational Surveillance New or Enhanced Models "Youth Employment Training Pilot Program"	DHHS	Continuation - Modified 7 Month Cost Extension		$ 49,908	10/1/03	4/30/04		9/11/03	$ 49,908
DPH	EMS Regional Symposium	DHHS	New	$ 18,850 $ 24,900		3/1/03	2/28/04	1 H33 MC 00145-01	3/19/03	$ 43,750
DPH	Trauma-EMS Systems Program	DHHS	Continuation - Unchanged	$ 40,000		8/1/03	7/31/04	5 H81MC00022-02-00	8/14/03	$ 40,000
DPH	Trauma-EMS Systems Program	DHHS	Continuation - Modified Carry Over Request		$ 4,639	8/1/03	7/31/04			
DPH	Minimizing Environmental Factors That Affect Asthma in Children	Environmental Council of States	New	$ 33,500		9/1/03	8/31/04			
DPH	Adult Blood Lead Epidemiology and Surveillance (ABLES) Program	DHHS	Continuation - Unchanged	$ 26,040		10/1/03	9/30/04			
DPH	Using Loving Support to Build A Breastfeeding Friendly Community	USDA	Amendment to Current Grant Supplemental Funds	$ 25,000		9/30/03	9/30/05	W159-02-004	8/12/03	$ 25,000
DPH	Reducing the Impact of Arthritis and Other Rheumatic Conditions	DHHS	Continuation - Modified Carry Over from Year 01 to 02		$ 24,769	7/1/03	6/30/04	U58 / CCU520292-02-01	7/15/03	$ 24,769
DPH	Public Health Conference Support Grant Program LOI A-79	DHHS	New	$ 18,848		9/15/03	9/14/04			
DPH	Public Health Conference, Nov 17-18, 2003 "Assessing & Addressing Environmental Health: At Home, School, Work & Play"	DHHS	New	$ 18,848		7/1/03	6/30/04	C13 / CCC523027-01	9/4/03	$ 18,848
DPH	Partnership for Healthy Babies in Wisconsin	USDA	New	$ 15,000		9/30/03	9/29/04	WI59-03-037	9/26/03	$ 15,000
DPH	Wisconsin Evidence-Based Promotion Programs For Older Adults	DHHS	New	$ 14,890		12/12/03	12/11/04			
DPH	Interpersonal Agreement: CDC and Chetna Mehrotra: Reimbursement for consultation on weight loss surgeries in WI	DHHS	New	$ 12,629		6/30/03	6/29/04			
DPH	MOU - Improve the health of WI communities through collaboration in public health education	WI-UW Madison	New	$ 7,500		7/1/01	6/30/04			
DPH	MOA - Farmers Market Nutrition Program Vendor Management	USDA	New	$ 5,100		2/1/03	12/31/03			
DPH	MOA - Provide Epidemiologic Support For The DHFS Minority Health Report	WPHHPI	New	$ 5,000		1/1/03	4/30/03			

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DPH	Consultation Agreement With Health and Society Scholars Program	UW-Medical School	New	$ 2,500		9/1/03	8/31/04			

Grant Sub-Total	$ 112,182,108	$ 41,517,076
Grant Total		$ 153,699,184

Total Grants	86	$ 153,699,184
-PRF Grants	74	$ 152,132,931
-PR Grants	12	$ 1,566,253

Descending Value	86	$ 153,699,184	%
-Greater than $1,000,000	17	$ 138,178,963	19.8%
-$500,001 & $1,000,000	7	$ 5,575,045	8.1%
-$100,001 & $500,000	37	$ 8,722,713	43.0%
-$50,001 & $100,000	9	$ 824,543	10.5%
-$10,001 & $50,000	12	$ 377,820	14.0%
-Less than $10,000	4	$ 20,100	4.7%

Submission From Wisconsin Public Health Association
Provided for Informational Purposes

POTENTIAL CRITERIA FOR
MEASURING SUCCESS IN
RESTRUCTURING PUBLIC HEALTH IN WISCONSIN,
INCLUDING CONSIDERATION FOR A PUBLIC HEALTH INSTITUTE

Draft Prepared March 17, 2004

SUCCESS MEASURE	MEASUREMENT TOOL	EVALUATION	CONCEPT OF FAILURE
Citizens of Wisconsin are healthier.	*The State Health Plan-Implementation Measures.	*All performance measures are met by 2010.	*Actions that reduce the probability of meeting State Health Plan Goals.
Wisconsin's public health system is supported with equitable, adequate and stable financing.	*Total funding level of public health in Wisconsin. (Definition of total funding = Funding from federal grants, GPR, PRO, foundation grants, other private grants across all partners.)	*Increase in total funding for public health activities. *Increase in funding from federal sources.	*Funding decreases and/or sources of funding are not balanced or sustained. *Loss of current levels of federal funding; failure to leverage state dollars with federal grants.
Public health systems partnerships (government, non-government, public, private, volunteer, academia, faith, etc.) are strengthened and public health outcomes improve.	*The degree to which privatization contracts increase the effectiveness and efficiency of achieving public health outcome goals without weakening public sector infrastructure. *Partnerships and collaboration at all levels.	*Meaningful quality criteria are established, monitored and achieved for each public-private contract. *Cost savings from privatization are returned to the public health system. *Social costs for delivering essential public health services decreases and positive outcomes increase.	*Contracts do not contain performance criteria related to health outcomes and/or contractors are not held accountable to meeting criteria. *Contracts are not let out competitively to private sector. *The cost of providing public health essential services increases and positive public health outcomes decline.

SUCCESS MEASURE	MEASUREMENT TOOL	EVALUATION	CONCEPT OF FAILURE
		*Partnerships foster shared planning, decision-making and resource-sharing.	*Unnecessary duplication of services or gaps in services. *Public sector loses control over terms/conditions of contract.
State government is a true steward for the health and well being of its citizens, and plans for the future.	*Governmental entities that provide for the Essential Services and Core Functions are able to carry out their missions.	*State public health programs needed to support the Essential Services continue or are created. *Per capita funding for public health in Wisconsin is in the top 10% of states nation wide.	*State public health programs needed to support Essential Services are eliminated, weakened or not created. *Per capita funding for public health in Wisconsin stays in the bottom 10% of states nation wide.
Local government is a true steward of government's responsibilities for the health and well being of its citizens and plans for the future.	*Governmental entities charged with responsibility for providing the Essential Services and Core Functions of public health carry out their missions.	*Local public health programs needed to support the Essential Services are created, continue or thrive. *Funding to local health programs is increased.	*Local public health programs needed to support Essential Services are not created, weakened or eliminated. *Funding to local health programs is reduced.
State and local governments will achieve a more comprehensive and coordinated approach to health policy.	*A balance is achieved and not diminished between state and local responsibilities for public health.	*Consensus-building tools are used to coordinate policies and activities.	*State and local governments do not work together to achieve a mutually agreed upon balance in their respective responsibilities. *Arbitrary decisions are made by state concerning local responsibility.
Sustainable commitment from the Governor and state legislature in support of prevention activities as both a	*Statutory authorities for public health. *Funding priorities.	*State and local governments have clear missions and mandates, working together supported by law and rule.	*State and local governments fail to understand and carry out their respective responsibilities.

SUCCESS MEASURE	MEASUREMENT TOOL	EVALUATION	CONCEPT OF FAILURE
health and economic benefit.		*State GPR is allocated to primary prevention.	*Statutes are not strong or robust enough to deal with modern public health issues.
If a public health institute is proposed, it is proposed with the true intention of transforming public health in Wisconsin by making the public health system stronger, more visible, more accessible and more valuable.	*The degree to which details for a public health institute are worked out publicly and with all public health partners before implementation begins.	*A progressive vision is created in line with national principles of public health as a discipline. *Institutional values parallel those established by the Turning Point partners. *Sustainability is addressed.	*The main goal of the institute is to reduce the number of state employees. *The public health community is not asked to help to create the vision. *The public health system is not stronger and its activities are marginalized.
If a public health institute is proposed, it should increase the amount, access and use of population health, health care and demographic data to inform policy and fiscal decision-making, epidemiology and surveillance.	*Amount, access and use of population, health care and demographic data. *The cost to public sector and private sector to access data. *The freedom to use the data.	*Public health system partners contribute to, and make greater, more beneficial use of, data gathered by the institute. *There are no new costs to access and use data.	*Access to population, health care and demographic data is more expensive, less timely, and less useful. *Public and private use of data is more restricted.
If a public health institute is proposed, it provides the impetus for development of a sufficient and competent workforce.	*Adequacy and distribution of public health workforce throughout Wisconsin. *Professional competencies of the public health workforce.	*The number of public health professionals working in the public health system and the diversity of the workforce increases. *The capabilities and competencies of the public health workforce are expanded. *Continuous learning opportunities are available, affordable and within reach.	*The number of public health workers decreases. *The public health workforce is not more diverse. *Skills and competencies of the public health workforce are not expanded.

SUCCESS MEASURE	MEASUREMENT TOOL	EVALUATION	CONCEPT OF FAILURE
All sectors of the public health system are equally empowered in governance of a public health institute if it is proposed.	*Oversight and accountability structures.	*Oversight bodies are representative of the public health system partners. *Accountability measures are established for institute administrators and Governing Boards.	*Nominal provision for public health system partners in the Public Health Institute governance structure. *Nominal accountability to the public to improve health. *Control of PH institute is dominated by one set of partners or those who fund it.